

FILED FEB 24 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5944

State File No.

Registrar's No. 1365

BIRTH NO.		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		State File No.		Registrar's No. 1365			
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY							
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS				c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS 2189							
d. FULL NAME OF HOSPITAL OR INSTITUTION 3415 HICKORY ST				d. STREET ADDRESS (If rural, give location) 18 3415 HICKORY ST							
3. NAME OF DECEASED (Type or Print) EMMA				a. (First)		b. (Middle) —		c. (Last) ANDERSON		4. DATE OF DEATH (Month) (Day) (Year) 2-8-50	
5. SEX F 3		6. COLOR OR RACE COL		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED 1		8. DATE OF BIRTH 12-26-87 62		9. AGE (In years last birthday) 1 13		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) ST. LOUIS, MISSOURI		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME Randolph Phillips				13b. MOTHER'S MAIDEN NAME EMMA				14. NAME OF HUSBAND OR WIFE Mr ANDERSON			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Ann Anderson 3415 Hickory St					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocardial insufficiency</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. INTERVAL BETWEEN ONSET AND DEATH 1 Year							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)				21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) HIOX			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)				21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 20 Feb, 1950, to 8 Feb, 1950, that I last saw the deceased alive on 8 Feb, 1950, and that death occurred at 1:00 p.m., from the causes and on the date stated above.											
23a. SIGNATURE W. H. Beaton				23b. ADDRESS 2743 Franklin				23c. DATE SIGNED 18 Feb			
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				24b. DATE 2-10-50		24c. NAME OF CEMETERY OR CREMATORY WASHINGTON PARK		24d. LOCATION (City, town, or county) ST. LOUIS CO.		24e. (State) MO.	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE FEB 1 1950 J. B. Sasser				25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS A. H. Walton 2707 TODDARD ST.							

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed Arthur L. Herliand

Licensed Embalmer No. 4221

P. O. Address 4049 St. Germain

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.